RISK AND PROTECTIVE FACTORS

Risk Factors for Unhealthy Adolescent Behaviors

Certain risk factors have been identified in longitudinal studies as predictors of adolescent health and behavior problems. Risk factors are divided into four domains: individual/peer, family, school and community.

I. Individual/Peer Domain Risk Factors

Rebelliousness.
Young people who feel they are not part of society or are not bound by rules, who don't believe in trying to be successful or responsible, or who take an actively rebellious stance toward society are at higher risk of drug abuse, delinquency, and school dropout.

Friends who engage in the problem behavior.
Young people who associate with peers who engage in a problem behavior – delinquency, substance abuse, violent activity, sexual activity, or dropping out of school – are much more likely to engage in the same problem behavior.

Favorable attitudes toward problem behavior.
During elementary school years, children usually express anti-drug, anti-crime, and pro-social attitudes and have difficulty imaging why people use drugs, commit crimes, and drop out of school. However, in middle school, as others they know participate in such activities, their attitudes often shift toward greater acceptance of these behaviors. This acceptance places them at higher risk.

Early initiation of the problem behavior.
The earlier young people drop out of school, use drugs, commit crimes, and become sexually active, the greater the likelihood that they will have chronic problems with these behaviors later. For example, research shows that young people who initiate drug use before the age of 15 are at risk of having drug problems than those who wait until after the age of 19.

II. FamilyDomain Risk Factors

A family history of high-risk behavior.
If children are raised in a family with a history of addiction to alcohol and other drugs, their risk of having alcohol or other drug problems themselves increases. If children are born or raised in a family with a history of criminal activity, their risk for delinquency increases. Similarly, children who are born to a teenage mother are morel likely to drop out of school themselves.

Family management problems.
Poor family management practices are defined as a lack of clear expectations for behavior, failure of parents to supervise and monitor their children, and excessively severe, harsh, or inconsistent punishment. Children exposed to these poor family management practices are at higher risk of developing substance abuse, delinquency, violence, teen pregnancy, and school dropout.

Family conflict.
Although children whose parents are divorced have higher rates of delinquency and substance abuse, it appears that it is not the divorce itself that contributes to delinquent behavior. Rather, conflict between family members appears to be more important in predicting delinquency than family structure. For example, domestic violence in a family increases the likelihood that young children will engage in violent behavior themselves. Children raised in an environment of conflict between family members appear to be at risk for substance abuse, delinquency, violence, teen pregnancy, and school dropout.

Parental attitudes and involvement in the problem behavior.
Parental attitudes and behavior toward drugs and crime influence the attitudes and behavior of their children. Children of parents who excuse their children for breaking the law are more likely to develop problems with juvenile delinquency. Children whose parents engage in violent behavior inside or outside the home are a greater risk for exhibiting violent behavior. In families where parents use illegal drugs, are heavy users of alcohol, or are tolerant of children's use, children are more likely to become drug abusers in adolescence. The risk is further increased if parents involve children in their own drug, or alcohol-using behavior – for example, asking the child to light the parent's cigarette or get the parent a beer from the refrigerator.

III. School Domain Risk Factors

Early and persistent antisocial behavior.
Boys who are aggressive in grades K-3 or who have trouble controlling their impulses are at higher risk for substance abuse, delinquency, and violent behavior. When a boy's aggressive behavior in the early grades is combined with isolation or withdrawal, there is an even greater risk of problems in adolescence. This also applies to aggressive behavior combined with hyperactivity.

Academic failure beginning in late elementary school.
Beginning in the late elementary grades, academic failure increases the risk of drug abuse, delinquency, violence, teen pregnancy, and school dropout. Children fail for many reasons, but it appears that the *experience* of failure itself, not necessarily ability, increases the risk of these problem behaviors.

Low commitment to school.
Lack of commitment to school means the child has ceased to see the role of student as a viable one. Young people who have lost this commitment to school are at higher risk for substance abuse, delinquency, teen pregnancy, and school dropout.

IV Community Domain Risk Factors

Availability of drugs.
The more easily available drug and alcohol are in a community, the greater the risk that drug abuse will occur in that community. Perceived availability of drugs in school is also associated with increased risk.

Availability of firearms.
Firearms, primarily handguns, are the leading mechanism of violent injury and death. Easy availability may escalate an exchange of angry words and fists into an exchange of gunfire. Research has found that areas of greater availability of firearms experience higher rates of violent crime including homicide.

Community laws and norms favorable toward drug use, firearms, and crime.
Community norms – the attitudes and policies and community holds in relation to drug use, violence, and crime – are communicated in a variety of ways: though laws and written policies, through informal social practices, through the media, and through the expectations that parents, teachers, and other members of the community have of young people. When laws, tax rates, and community standards are favorable, or even when they are just unclear, young people are at higher risk.

Transitions and mobility.
Even normal school transitions can predict increases in problem behaviors. When children move from elementary school to middle school or from middle school to high school, significant increases in the rate of drug use, school dropout, and anti-social behavior may occur. Communities characterized by high rates of mobility appear to be at an increased risk of drug and crime problems. The more people in a community move, the greater is the risk of criminal behavior.

Low neighborhood attachment and community disorganization.
Higher rates of drug problems, crime, and delinquency and higher rates of adult crime and drug trafficking occur in communities or neighborhoods where people have little attachment to the community, where the rates of vandalism are high, and where surveillance of public places is low.

Extreme economic and social deprivation.
Children who live in deteriorating neighborhoods characterized by extreme poverty, poor living conditions, and high unemployment are more likely to develop problems with delinquency, teen pregnancy, and school dropout or to engage in violence toward others during adolescence and adulthood. Children who live in these areas *and* have behavior or adjustment problems early in life are also more likely to have problems with drugs later on.

PROTECTIVE FACTORS

Promotion of protective factors has been demonstrated to reduce risk of problem behavior including drug use, violent or disruptive behavior, teen pregnancy, and dropping out of school. Promoting protective factors involves four domains:

Individual (Domain)

- Resilient temperament
- Positive social orientation

In Families (Domain)

- Bonding
- Healthy beliefs and clear family standards for behavior

In School (Domain)

- Opportunities for involvement
- Rewards/recognition for prosocial performance/involvement
- Healthy beliefs and clear standards for behavior

In the Community (Domain)

- Opportunities for prosocial involvement
- Rewards/recognition for prosocial involvement
- Healthy beliefs and clear community standards for behavior

Risk Focused Prevention

The premise of risk-focused prevention is to identify problem behaviors and then find ways to reduce the risks. Risk factors and problem behaviors are divided into four categories: community, family, school and individual/peer. Risk-focused prevention assumes the following:

- Risks exist in the community, the family, in schools and individuals – prevention is everybody's business.
- The greater the number of risk factors present, the greater the risk. Some evidence indicates that risk incases exponentially with exposure to more than one risk factor.
- Interventions can reduce multiple problems such as substance abuse, delinquency, and youth violence.
- Risk factors show consistent effects across diverse groups.
- Protective factors can lessen risk.

Prevention Programming

Risk-focused prevention involves seven programming principles:

1. Focus on reducing known risk factors. Know which risk factors the program will address and how the program activities will reduce the risk factors.
2. Enhance protective factors while reducing risk. If a prevention program reduces risk in a way that strengthens protective factors, a child is double protected.
3. Address risk factors at the appropriate developmental stage and as early as possible.
4. Target programs to those exposed to multiple risk factors.
5. Deliver programs to reach the diverse racial and cultural groups in a community.
6. Work together with other people and organizations to address multiple risk factors.
7. Address the risk factors most prevalent in a particular community.

Prevention Principles for Community Programs

- To be comprehensive, does the program have components for the individual, the family, the school, the media, community organizations, and health providers?

- Does the prevention program use media and community education strategies to increase public awareness, attract community support, reinforce the school-based curriculum for students and parents, and keep the public informed of the program's progress?

- Can program components be coordinated with other community efforts to reinforce prevention messages (for instance, can training for all program components address coordinated goals and objectives)?

- Are interventions carefully designed to reach different populations at risk, and are they of sufficient duration to make a difference?

- Does the program follow a structured organizational plan that progresses from needs assessment through planning, implementation, and review to refinement, with feedback to and from the community at all stages?

- Are the objectives and activities specific, time-limited, feasible (given available resources), and integrated so that they work together across program components and can be used to evaluate program progress and outcomes?

Prevention Principles for Family-Based Programs

- Do the family-based programs reach families of children at each stage of development?

- Do the programs train parents in behavioral skills to
  - Reduce conduct problems in children;
  - Improve parent-child relations, including positive reinforcement, listening and communication skills, and problem solving;
  - Provide consistent discipline and rulemaking; and
  - Monitor children's activities during adolescence?

- Do the programs include an educational component for parents with drug information for them and their children?

- Are the programs directed to families whose children are in kindergarten through 12th grade to enhance protective factors?

- Do the programs provide access to counseling services for families at risk?

Risk Factor Data

Risk factors are categorized in four domains: individual, family, school, and community. Key risk factors and related risk indicators used in SDFSCA needs assessments are listed below:

	Risk Factors		**Indicators**
I.	***Individual Domain Risk Factors***		
1.	Alienation and rebelliousness	I.1.a.	Suicide death rates by age
		I.1.b.	Reported gang involvement
		I.1.c.	Vandalism and graffiti damage
2.	Friends who engage in a problem behavior	I.2.a.	Adolescents involved with juvenile justice system
		I.2.b.	Reported alcohol and other drug use by friends
		I.2.c.	Adolescents in treatment
		I.2.d.	Adolescents diagnosed with sexually transmitted diseases
		I.2.e.	Adolescent pregnancies
3.	Favorable attitudes toward the problem behavior	I.3.a.	Disapproval of drug use
		I.3.b.	Perceived harmfulness of drug use
		I.3.c.	Attitudes about marijuana laws
4.	Early initiation of the problem behavior	I.4.a.	Grade of first ATOD use
		I.4.b.	Age of initial sexual activity
		I.4.c.	Dropouts prior to 9th grade
		I.4.d.	Violence-related arrests
5.	Constitutional factors	I.5.a.	Sensation seeking and low harm avoidance*
		I.5.b.	Poor impulse control*
		I.5.c.	Child of alcohol parent*
		I.5.d.	Hyperactivity, attention deficit disorder*
		I.5.e.	Poor ability to delay gratification*
		I.5.f.	Peer rejection*
II.	***Family Domain Risk Factors***		
1.	Family history of the problem behavior	II.1.a.	Adults in treatment
		II.1.b.	Less than 12 years education
		II.1.c.	Parents/other adults in prison
		II.1.d.	Adult illiteracy
2.	Family management problems	II.2.a.	Reported child abuse and neglect cases
		II.2.b.	Children living outside the family
		II.2.c.	Runaway reports
		II.2.d.	Children living in foster care
3.	Family conflict	II.3.a.	Divorce
		II.3.b.	Households with spouse absent
		II.3.c.	Domestic violence reports

	Risk Factors		Indicators
II.	***Family Domain Risk Factors - Continued***		
4.	Favorable parental attitudes and involvement in the behavior	II.4.a.	Adult violent crime arrests
		II.4.b.	Adult property crime arrests
		II.4.c.	Adult alcohol-related arrests
		II.4.d.	Babies born affected by alcohol and other drug use
		II.4.e.	Drug use during pregnancy
III.	***School Domain Risk Factors***		
1.	Early and persistent antisocial behavior	III.1.a.	Elementary school disciplinary problems
		III.1.b.	Elementary school special education placement for behavioral disorders or attention deficit disorder.
		III.1.c.	Elementary school students diagnosed with behavioral disorders or attention deficit disorder
2.	Academic failure in elementary school	III.2.a.	Grade retention – 8th graders with one grade repeated
		III.2.b.	Grade retention – 8th graders with two grades repeated
		III.2.c.	ACT or SAT test scores
		III.2.d.	Reading proficiency
		III.2.e.	Math proficiency
		III.2.f.	GED diplomas issued
3.	Lack of commitment to school	III.3.a.	Dropout rates
		III.3.b.	Average daily attendance/truancy rates
IV.	***Community Domain Risk Factors***		
1.	Availability of drugs	IV.1.a.	Trends in perceived availability by 12th graders
		IV.1.b.	Perceived availability 8th, 10th, & 12th graders
		IV.1.c.	Per capita alcohol consumption
		IV.1.d.	Sales of alcoholic beverages/liquor sales outlets
2.	Availability of firearms	IV.2.a.	Crimes involving firearms (includes robberies, assaults, homicides)
		IV.2.b.	Arrests for adult possession of illegal firearms
		IV.2.c.	Arrests for juvenile possession of illegal firearms
3.	Community laws and norms favorable toward drug use, firearms, and crime	IV.3.a.	Juvenile arrest for drug law violations
		IV.3.b.	Juvenile arrests for violent crimes
		IV.3.c.	Juvenile convictions for AOD-related offenses
		IV.3.d.	Juvenile convictions for violent crimes
		IV.3.e.	Adult and juvenile DUI arrests
		IV.3.f.	Average penalties for DUI convictions
		IV.3.g.	Quantity of drugs seized

3.	Community laws and norms favorable toward drug use, firearms, and crime - *Continued*	IV.3.h.	Areas targeted by law enforcement for drug clean-up
		IV.3.i.	Juvenile arrests for curfew, vandalism and disorderly conduct
		IV.3.j.	Secondary school disciplinary actions for ATOD and violence-related offenses
4.	Transition and mobility	IV.4.a.	Existing and new home sales
		IV.4.b.	Rental unit turnover
		IV.4.c.	Student movement in and out of school
5.	Low neighborhood attachment and community disorganization	IV.5.a.	Voter registration/voting rates
		IV.5.b.	Number of churches/synagogues
6.	Extreme economic deprivation	IV.6.a.	Families/children living below poverty level
		IV.6.b.	Unemployment rate
		IV.6.c.	Free and reduced lunch program
		IV.6.d.	Single female head of household as percentage of all households
Source: Most of the indicators listed above are from Communities That Care Data Workbook, Developmental Research and Programs, Inc., 1993. Indicators marked (*) were developed from studies presented in Understanding and Preventing Violence, Albert J. Reiss, Jr. and Jeffrey A. Roth, Editors, 1993.			

Making Sense of Data Gathered by a Needs Assessment

Too often needs assessment stops with the collection of various "pieces" of information. To guide the program planning process, the information needs to be more closely examined and synthesized. In the case of information about drug use, analysis of various pieces of data can help identify patterns which have programmatic implication.

Data	***Possible programmatic implications***
What drugs are being used	Greater emphasis in curriculum and in other prevention efforts on most prevalent drugs
Whether the pattern of use is widespread among youth or if use is concentrated in a more limited segment of the population.	If evidence of concentration, target greater resources to higher risk population.
Whether particular drugs are being used by youth at different ages. For example, higher prevalence of inhalant use among middle schoolers and higher prevalence of alcohol use at the upper high school ages.	Give greater emphasis at the middle school to inhalant use. Give greater emphasis at the high school level to alcohol use.
Existing student perceptions of safety in school, at school-sponsored events, or traveling to school	Sharpen focus of school safety efforts to areas of greatest need.
What other prevention resources/activities are being implemented in the community	Design comprehensive program to avoid duplication, take advantage of existing resources, and fill in service gaps.

Types of Data Used in Needs Assessments

SDFSCA Performance Indicators

"Indicators" *are factors which research has identified as predictive of subsequent ATOD use, i.e., they indicate the likelihood of ATOD use.*

Certain data has been identified as key indicators of youth substance abuse and violence. Among objective data to be included in a SDFSCA needs assessment are the following:

	SDFSCA Indicators	**Key Source of Data**
1.	Use of alcohol and other drugs	
	1.a. Prevalence of use among students	Student surveys
	1.b. Age of first use among students	Student surveys
	1.c. Alcohol/other drug-related arrests of youth in community	Law enforcement records
2.	Incidence of violence and other crime in schools	
	2.a. Guns and other weapons brought to school	
	2.b. Students felt unsafe	Student surveys; school climate surveys
	2.c. Students threatened/victimized	Student surveys; school climate surveys; Law enforcement records
	2.d. Criminal incidents in schools	School disciplinary records and law enforcement records
	2.e. Crimes using weapons in schools	School disciplinary records and law enforcement records
	2.f. Violence-related arrests of school aged youth in community	Law enforcement records

Judging the Effectiveness of Current Prevention Efforts

School divisions are working very hard on programming for violence and drug use prevention. However, the schools cannot do this job alone and their programs are likely to be ineffective if activities implemented are not research-based. Local school divisions and their local advisory councils are encouraged to check if their prevention efforts contain the school, family, community, and media elements described in ***Preventing Drug Use Among Children and Adolescents – A Research-Based Guide.***

The following checklist can assist in determining whether specific programs include research-based prevention principles:

Prevention Principles for School-Based Programs

- Do the school-based programs reach children from kindergarten through high school? If not, do they at least reach children during the critical middle school or junior high years?

- Do the programs contain multiple years of intervention?

- Do the programs use a well-tested, standardized intervention with detailed lesson plans and student materials?

- Do the programs teach drug-resistance skills through interactive methods (modeling, roleplaying, discussion, group feedback, reinforcement, extended practice)?

- Do the programs foster prosocial bonding to the school and community?

- Do the programs:
  - Teach social competency (community, self-efficacy, assertiveness) and drug resistance skills that are culturally and developmentally appropriate;
  - Promote positive peer influence;
  - Promote antidrug social norms;
  - Emphasize skills-training teaching methods; and
  - Include an adequate “dosage” (10 to 15 sessions in year 1 and other 10 to 15 booster sessions)?

- Is there periodic evaluation to determine whether the programs are effective?

Needs Assessment: Two Examples

Example 1: Anytown High School

Problems Observed:

Much conflict among students and between students and teachers; current disciplinary responses are reactive, time-consuming, and seem only marginally effective; too much teacher time spent intervening with students rather than focusing on instruction.

Objective Data from Needs Assessment:

- 20% increase in number of fights this year compared to last.
- More than twice as many knives confiscated this year (14 total) to last year (6 totals).
- Faculty advisory council survey ranked student fighting as #1 safety issue for teachers.
- Parent concerns about school safety are increasing as reflected in PTA survey and increased expressions of concern in parent contact with school personnel.
- 15% increase in assault cases in juvenile court; 28% increase in number of cases involving possession of firearms.

Risk Factors Targeted for Reduction:

- Reduce alienation and rebelliousness
- Reduce rewards for anti-social behaviors

Protective Factors Targeted for Enhancement:

- Increase opportunities and rewards for positive involvement in school
- Increase social- and self-competency skills
- Improve communication skills
- Enhance positive peer relationships

Example 2: Our County Middle and High Schools

Problems Observed:

Administrators and student services professionals at Our County Middle and High Schools have seen an increase in the number of students with school performance and attendance problems who have been found to have alcohol and other drug problems.

Objective Data from Needs Assessment:

- A PRIDE survey conducted in 1998 found levels of alcohol use among Our County 10^{th} and 12^{th} graders to be higher than national averages
- A 20% increase this year in the number of alcohol-related offenses at school and school-sponsored activities
- A 26% rise in juvenile court referrals involving underage drinking and possession of alcohol
- Recent Office on Youth community needs assessment identified a large number of alcohol retail outlets and underage drinking ranked high among concerns of parents and law enforcement personnel

Risk Factors Targeted for Reduction:

- Delay initiation of substance use
- Reduce the number of friends who use
- Decrease favorable attitudes toward use

Protective Factors Targeted for Enhancement:

- Increase social skills
- Increase opportunities and rewards for positive involvement in school

Goals and Objectives

Goals define the overall direction of the program and state what is to be accomplished. They provide the foundation for specific objectives and activities that ultimately define the program.

A goals is a measurable statement of desired longer-term, global impact of the prevention program.

Well-formulated **goals** reflect the longer-term, global effects the prevention program is intended to achieve. Goals typically address changes in alcohol and other drug use measures or incidence of violence or in terms of changes in risk or protective factor indicators.
Examples:

- Reduced alcohol use among teens
- Reduced number of disciplinary suspensions
- A change in group norms or public policy

Defining Measurable Objectives: What Outcomes Do We Wish to Achieve:

What to strive for:

- Objectives are statements of precise and measurable results for a specified period that establish you program's criteria for success.
- Outcomes should describe the specific change in behavior, knowledge, attitudes, or feelings that program activities will produce.
- Objectives should be measurable, realistic and attainable.
- Objectives should be linked to specific goals.

Pitfalls to avoid:

- Defining outcomes too broadly so that they appear to be goals.
- Describing outcomes in terms which are not measurable.
- Only listing knowledge based outcomes.
- Listing program activities as your only outcomes.
- Listing outcomes which are not clearly linked to the overall goals of the program.
- Listing outcomes which are not appropriate for the target population.

The relationships between goals, objectives and program activities are highly interactive. Activities are designed and implemented to achieve objectives which support goals. The link between goals, objectives and activities should be clearly evident.

The ABCDE Method of Writing Measurable Goals and Objectives

Both goals and objectives need to be specific and measurable. By including the ABCD components, you will state the who, what, to what degree, and by when information for your program goals and objectives.

Audience
The population/target audience for whom the desired outcome is intended.

Behavior – what?
What is to happen? A clear statement of the behavior change/result expected.

Condition – by when?
The conditions under which measurements will be made. This may refer to the timeframe and/or upon implementation of a specific intervention.

Degree – by how much?
The quantification of, or the level of, results expected. This often invovles measuring change in comparison to an identified baseline.

Evidence – as measured by?
Defines the method of measuring the change expected. The degree of change (se forth above) will be measured using a specified instrument or criterion.

Establishing Goals Which Are Measurable

For purposes of SDFSCA program planning and evaluation, the goal statement must include each of the five elements on previous page.

Example 1: Anytown High School

Goal:

Both adults and students at Anytown High School will successfully manage and resolve conflicts after full implementation of the Creating the Peaceable School (CPS) Program, as evidenced in May 2000 by 25% reductions in the number of fights and the number of weapons brought to school and by 15% improvements ins student, teacher, and parent perceptions of school safety as measured by the School Climate Survey.

Audience	Both adults and students at Anytown High School
Behavior	Successfully manage and resolve conflicts
Condition	After full implementation of the Creating the Peaceable School Program
Degree	25% reduction in number of fights and weapons; 15% improvements in perceived school safety
Evidence	Disciplinary records; School Climate Survey

Example 2: Our County Middle and High School

Goal:

Reduce by 10% youth alcohol and other drug use as reported by Our County Middle and High School students on the May 2000 PRIDE Survey following implementation of a comprehensive student assistance programs.

Audience	Our County Middle and High School students
Behavior	Reduction in use of alcohol and other drug use
Condition	Following implementation of a comprehensive student assistance program; by May 2000
Degree	10% reduction
Evidence	PRIDE Survey

Defining goals: what Impact Do We Hope to Have?

What to strive for:

- Goals are general statements, which collectively describe the mission of the program.
- Goals should describe in very broad terms what the program wants to accomplish with the target population.
- Each goal should have one or more measurable outcome associated with it.

Pitfalls to avoid:

- Defining goals too narrowly so that they appear to be outcomes.
- Choosing goals that are inappropriate for the designated target population.
- Limiting goals to a description of program activities rather than addressing the overall changes that these activities are designed to produce in the target population.

"Goals and objectives should be developed at the beginning;
<u>then</u> activities are designed to achieve the goals and objectives."

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